UNUMPROVIDENT

Life Insurance Election of Portability Coverage

Unum Life Insurance Company of America
Portability/Conversion Unit
2211 Congress Street, Portland, ME 04122
1-800-343-5406

You may be eligible to continue your Life coverage. To apply, you must complete this form and send it to Unum within 31 days after your group insurance coverage ends. **You are not eligible to apply for portable coverage for yourself and your dependents if you have a medical condition which has a material effect on life expectancy. Also, any dependent is not eligible for portable coverage if he or she has a medical condition which has a material effect on life expectancy.** If you are not eligible to apply for portable coverage or your portable coverage ends, you or your dependents may qualify for conversion coverage. Ask your employer for a conversion application form (which includes cost information).

EMPLOYER COMPLETES BLUE SECTIONS

Indicate how frequently you wish to be billed and include your first premium payment (based on your selection) to Unum at the address shown above. We recommend that you obtain or verify your rates with the plan administrator. You must include your check or money order with this election form. **Make your check or money order payable to Unum.**

Select a premium payment option: ☐ Quarterly (monthly premium x3) ☐ Semi-Annually (monthly premium x6) ☐ Annual (monthly premium x12)

Company Name		Plan Number / Division Number:		
		Insured Effective Date: _ _ / _ _ / _ _ _ _		
Insured Name (last, first, initial)		Home Telephone #:		
		Work Telephone #:		
Insured Mailing Address (Street, PO Box, City, State, Zip)			Current Annual Earnings	
Social Security Number	Date of Birth _ _ / _ _ / _ _ _ _	Date Coverage Ended: _ _ / _ _ / _ _ _ _ Reason:	Sex Male	Female

Check One: Have you used tobacco in the last 12 months? ☐ **yes** ☐ **no**

Please complete the information below. You may keep the same level of coverage or decrease coverage. You may also increase coverage or add dependents (if employer's plan has dependent coverage) subject to medical evidence of insurability. Note: For specific plan maximums, plan minimums, rounding rules and reduction formulas refer to your group certificate booklet.

	Yourself	Spouse	Child
Current Life Amount:			
I request a change to:			

Spouse Name: _____ Spouse date of birth: _ _ / _ _ / _ _ _ _

Spouse Social Security No.: _____

Name and address of Beneficiary: _____ **Relationship to you:** _____

_____

Social Security No. of Beneficiary: _____ **Date of Birth of Beneficiary:** _ _ / _ _ / _ _ _ _

I understand and agree to the following:

1. Any coverage chosen on this election form will be issued in accordance with the portability provision contained in the employer's Unum group term life coverage under which this coverage is offered and is subject to satisfaction of the conditions provided therein.
2. I CERTIFY THAT NEITHER I NOR MY DEPENDENTS FOR WHOM I AM ELECTING COVERAGE HAVE A MEDICAL CONDITION WHICH HAS A MATERIAL EFFECT ON LIFE EXPECTANCY. I UNDERSTAND THAT UNUM IS RELYING ON THIS CERTIFICATION AS A MATERIAL CONDITION TO ITS AGREEMENT TO PROVIDE THIS PORTABLE COVERAGE.
3. If Unum determines at a later date that I was not eligible due to such a medical condition on the date portability coverage was elected for me or my dependents, any life benefits payable will be reduced to the amount of whole life coverage that my or my dependents' premium would have purchased under the whole life policy offered through the Conversion Privilege.
4. If Unum determines at a later date that one or more of my dependents were not eligible due to such a medical condition on the date that portability coverage was elected by them or for them, any life benefits payable under their coverage will be reduced to the amount of whole life coverage that their premium would have purchased under the whole life policy offered through the Conversion Privilege.
5. Portability coverage will become effective the day after your group coverage terminates subject to Unum receiving a completed election form and the first premium within 31 days from the date your group coverage terminates.

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Insured Signature	Date	Employer Signature	Date